

# **EXHIBIT A**



## CERTIFICATE OF ACCURACY

STATE OF NEW YORK )

SS:

COUNTY OF KINGS )

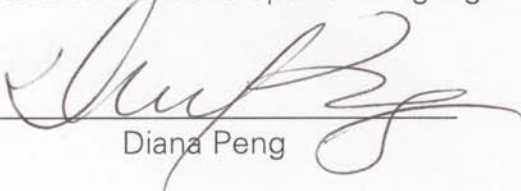
This is to certify that the attached documents:

**Certificate of Death of Pablo Tirado Ayala, issued by the Department of Health Demographic Registry on December 23, 2009 in Manati, Puerto Rico;**

**Last Will and Testament of Pablo Tirado Ayala, issued and certified by Oscar Sánchez Lamboy, Notary Public and recorded by the Office of the Director of Notarial Inspection on August 11, 1992 in Manati, Puerto Rico;**

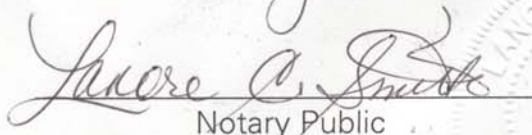
**Certification of the Record of the Last Will and Testament Registration of Pablo Tirado Ayala, issued by the Office of the Director of Notarial Inspection on August 11, 1992 in Manati, Puerto Rico**

are, to the best of my knowledge and belief, a true, complete, and accurate translation from the Spanish language into the English language.

  
Diana Peng

Sworn to and subscribed before me

this 15<sup>th</sup> day of June 2010

  
Notary Public

LANORE C. SMITH  
NOTARY PUBLIC, State of New York  
No. 01SM6162573  
Qualified in Kings County  
Commission Expires March 12, 20 11

NUMBER 1467163
Death Number

AREA NUM- BER	YR	Register NUMBER	CERTI- FICATE NUMBER
152	2009	0188	1039

DEPARTMENT OF HEALTH  
DEMOGRAPHIC REGISTRY  
Certification of Death

1. Place of death a. Municipality <i>Manatí</i>		b. Neighborhood <i>Cotto Sur</i>		1c. Place (Choice only one) Hospital <input type="checkbox"/> DOA <input type="checkbox"/> Outpatient ER <input type="checkbox"/> Inpatient <u>Other</u> <input type="checkbox"/> Convalescent home <input checked="" type="checkbox"/> Nursing home <input type="checkbox"/> Home <input type="checkbox"/> Other		2. Usual residence of the deceased (Where did he/she live? If in an institution: give the residence prior to admission) a. Municipality <i>Manatí</i> b. State or Country <i>PUERTO RICO</i>											
d. Name of hospital or other institution (If death did not occur in a hospital or institution give the address.) <i>Virgilio Ramos Home</i>		e. Village, zone or place  f. [Length of stay in Hospital or Institution] <i>6 months</i>		c. Neighborhood <i>Pugnado</i>		d. Village, zone or place		e. Urban <input type="checkbox"/> Rural <input checked="" type="checkbox"/>		f. Address (For Urban area- Street and Number) <i>RR-2 Box 604</i>							
3. First and last name of the deceased <i>Pablo Tirado Ayala</i>				4. Date and Time of Death		Time <i>11:55 PM</i>		Month <i>12</i>		Day <i>21</i>		Year <i>2009</i>		5. Last school year completed.			
														Education Intermediate Secondary (0-13)		[College] University (14 or [more])	
														<i>4th grade</i>			
6. Gender <i>Male</i>		6 a. Marital Status Never married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Divorced..... <input type="checkbox"/> Widowed <input type="checkbox"/>		6 b. Name of Spouse <i>Antonia Ramírez Fierro</i>		7. Date of Birth		8. Age (in years) <i>90</i>		If less than one year		If less than 24 hours					
										Mos.				Days			
										Month <i>AUG</i>				Day <i>21</i>		Year <i>1919</i>	
10 a. Usual Occupation (Type of work performed during the majority of life, even if retired) <i>Public [chauffer]</i>				10b. Type of business or industry <i>Own business</i>		10 c. Date on which last worked <i>1977</i>		11. Born in: Municipality <i>Manatí</i>  State or Country <i>PUERTO RICO</i>				12. Citizenship <i>U.S.A.</i>					
						10 d. Years worked in this occupation <i>20 years</i>						13. Residence in Puerto Rico <i>70 years</i>					
14. Father's name and surname: <i>Pablo Tirado</i>						15. Mother's name and maiden name: <i>Rosa Ayala</i>											
14 a. Born in: Town <i>Manatí</i> State or Country <i>PUERTO RICO</i>						15 a. Born in: Town <i>Manatí</i> State or Country <i>PUERTO RICO</i>											
16. Was the deceased a member of the United States Armed Forces? Yes _____ No <u>  x  </u> Wars/Dates _____ Unknown <input type="checkbox"/>				17. Social Security No. <i>303322141</i> None <input type="checkbox"/> Unknown <input type="checkbox"/>		18. Informant: a. Name: <u><i>Ángel Ramírez Colón</i></u> b. Signature <u>[signature]</u>				18 c. Informant's Exact Address <i>Villa Forestal Calle [illegible] Manatí</i>				18 d. Relationship to the deceased <i>Foster son</i>			
19. TO THE PERSON DECLARING THE DEATH Complete from 19 a-c only if the certifying physician is not available at the time of death to certify the cause of death.				MEDICAL CERTIFICATION  IMMEDIATE CAUSE  (illness or direct condition that lead to the death)  Indicate in order the conditions that lead to the immediate cause. WRITE THE PRINCIPAL CAUSE LAST. [illegible] (Illness or injury that caused the events leading to the death.		19 a. To the best of my understanding the death occurred at the time, on the date and in the place indicated above.  Signature <u>[signature]</u> Title <u>[physician]</u> a. <u><i>Respiratory arrest</i></u> b. <u><i>Aspiration pneumonia</i></u> c. <u><i>Alzheimer VII End Stage</i></u> d. _____				19 b. License No. <i>16,600</i>  Interval between its start and death _____ _____ _____ _____		19 c. Date of Signature					
												MO.    DAY    YR. <i>12    21    2009</i>					
20. CAUSE OF DEATH: Enter only one cause in each line (a), (b), and (c). Cause of death does not mean the way the deceased died such as cardiac arrest, [illegible], etc. It means the illness, injury or complication that caused the death. <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				23. Was an autopsy performed? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		24. Institution where autopsy was performed.				25. Was the prosecutor notified? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
										21. Was the deceased pregnant during the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No							
										22. Medical Record No.							
26 a. Date of operation (if applicable)		26 b. Most significant findings from the operation:		27 a. Type of death <input checked="" type="checkbox"/> [natural <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> pending investigation <input type="checkbox"/> could not be determined						27 b. Place where the injuries occurred? (Home, building, factory, etc.)							
27 c. Municipality		Place or neighborhood		State or country		27 d. Date of Injury		27 e. Did the death occur at work?		27 f. How did the injuries occur?							
Mo.		Day		Yr.		Hr.											
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																	

28 a. I CERTIFY that I attended to the deceased from <u>  May  </u> <i>2009</i> until <u>  December  </u> <i>21</i> , <i>20 09</i> , and that I last saw him/her alive on _____ 19_____, and that the death occurred as a consequence of the causes and on the date and time indicated above.						28b. I did not attend to the deceased and this Certification is completed on the basis of information obtained from a _____ of the deceased performed by a _____.							
29 a. Certifying doctor: Name <u>[Osvaldo] Medina Cotto</u> 2_Signature <u>[signature]</u>				29b. License No. of Certifying doctor <i>16,600</i>		29 c. Exact Address of Certifying doctor <i>Calle 685 KM 4.0 BO: Tierras Nuevas, Manatí</i>		29 d. Date of the signature					
								Month <i>12</i>		Day <i>21</i>		Year <i>2009</i>	
30 a. Burial <input checked="" type="checkbox"/> <input type="checkbox"/> Other (specify) Transfer <input checked="" type="checkbox"/> <input type="checkbox"/> Cremation <input type="checkbox"/> <input type="checkbox"/> _____				30 b. Date		30 c. Name of Cemetery or Crematorium <i>Valle de los Sueños</i>				30 d. Address <i>Manatí, Puerto Rico</i>			
Month <i>DEC</i>		Day <i>23</i>		Year <i>2009</i>									
31. To be completed by the Undertaker or other individual in charge of burial a. I certify: <input checked="" type="checkbox"/> he/she was embalmed <input type="checkbox"/> he/she was not embalmed b. <u><i>Edgardo González</i></u> Signature [signature] c. Name/address of funeral parlor <i>M. González [illegible] Manatí</i>				32 a. Was he/she embalmed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b. <u><i>Cándido González Meléndez</i></u> Name of Embalmer c. License No. <u><i>189</i></u>		33. Race of deceased <input checked="" type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other		34. Date of Entry					
				c. Signature [signature]				Month <i>December</i>		Day <i>23</i>		Year <i>2009</i>	
								35. Registrar's Signature [signature]					

THIS IS AN ABSTRACT OF THE DEATH  
CERTIFICATE OFFICIALLY RECORDED IN  
THE DEMOGRAPHIC REGISTRY OF PUERTO  
RICO UNDER THE AUTHORITY GRANTED  
BY LAW 24 OF APRIL 22, 1931.

[signature]  
SECRETARY OF HEALTH

[signature]  
STATE REGISTRAR

[originally in English]  
THIS IS AN ABSTRACT OF THE  
RECORDS FILED IN THE  
DEMOGRAPHIC REGISTRY OF  
PUERTO RICO ISSUED UNDER THE  
AUTHORITY OF LAW 24, APRIL 22,  
1931.

[emblem]  
Commonwealth of Puerto Rico  
Department of Health

[revenue stamp:]  
\$5    \$5  
INTERNAL REVENUE STAMP  
TREASURY  
COMMONWEALTH  
OF PUERTO RICO  
D23991162



DEPARTAMENTO DE SALUD  
(DEPARTMENT OF HEALTH)  
REGISTRO DEMOGRAFICO  
(DEMOGRAPHIC REGISTRY)  
CERTIFICACION DE DEFUNCION  
(CERTIFICATION OF DEATH)

NUMERO  
**A467163**

1. Lugar de Defunción (Place of Death)		2. Residencia Habitual de Falecido (Where lived? If in a institution, Res. before death)	
a. Municipio: <b>Manati</b>	b. Barrio: <b>Cottoy</b>	a. Municipio: <b>Manati</b>	b. Estado o País: <b>Puerto Rico</b>
3. Nombre y apellidos del fallecido (Deceased Name): <b>Pablo Tirado Ayala</b>		4. Hora y Fecha de la Defunción (Death Time Date): <b>11:55 PM 12/21/2009</b>	
5. Sexo: <b>Male</b>	6. Estado Civil (Marital Status): <b>Never Married</b>	7. Fecha de Nacimiento: <b>April 21, 1919</b>	8. Edad (en años): <b>90</b>
9. Último grado escolar completado: <b>High School</b>		10. Ocupación Habitual (Trabajo realizado durante la mayor parte de su vida. No use el término "retirado"):	
11. Natural de: <b>Manati, Puerto Rico</b>		12. Ciudadano de: <b>U.S.A.</b>	
13. Nombre y apellidos del Padre (Father's Name): <b>Pablo Tirado</b>		14. Nombre y apellidos de la Madre (Mother's Surname): <b>Rosa Ayala</b>	
15. Natural de: <b>Manati, Puerto Rico</b>		16. Dirección Exacta del Informante: <b>Calle 16600</b>	
17. Número de Seguro Social: <b>393322141</b>		18. Relación con el Falecido: <b>Hijo</b>	
19. A mi mejor entender la muerte ocurrió en la hora, fecha y lugar arriba indicado.		20. Dirección Exacta del Médico que Certifica: <b>Carretera 685 Manati</b>	
21. ¿Estuvo la fallecida embarazada en el último año? <input checked="" type="checkbox"/>		22. Número del Record Médico:	
23. ¿Se practicó Autopsia? <input checked="" type="checkbox"/>		24. Institución donde se hizo la autopsia:	
25. Se refirió al fiscal: <input checked="" type="checkbox"/>		26. Hallazgos más importantes de la operación:	
27. Tipo de muerte: <input checked="" type="checkbox"/> natural <input type="checkbox"/> accidente <input type="checkbox"/> suicidio <input type="checkbox"/> homicidio <input type="checkbox"/> pendiente de investigación <input type="checkbox"/> no pudo determinarse		28. ¿Ocurrió mientras trabajaba? <input type="checkbox"/> Si <input checked="" type="checkbox"/> No	
29. ¿Cómo ocurrió la lesión? <input type="checkbox"/> Si <input checked="" type="checkbox"/> No		30. Fecha de la operación: <b>Dec-21-09</b>	
31. Certificado que asiste al fallecido desde: <b>Manati</b>		32. NO asiste al fallecido y esta Certificación se hace a base de información suministrada por: <b>Manati</b>	
33. Médico que Certifica: <b>Dr. Tierras Nueva, Manati</b>		34. Fecha de la Firma: <b>12/21/2009</b>	
35. Dirección Exacta del Médico que Certifica: <b>Carretera 685 Manati</b>		36. Nombre del embalsamador: <b>Edo. Guzmán</b>	
37. Número de Licencia del Médico que Certifica: <b>16600</b>		38. Fecha: <b>Dec-23-2009</b>	
39. Nombre del embalsamador: <b>Edo. Guzmán</b>		40. Color o Raza del Falecido: <input checked="" type="checkbox"/> Blanco <input type="checkbox"/> Negro <input type="checkbox"/> Otro	
41. Número de licencia: <b>189</b>		42. Fecha de Registro: <b>December 23, 2009</b>	
43. Firma del Registrador: <b>[Signature]</b>		44. Firma del Médico: <b>[Signature]</b>	

ESTE ES UN ABSTRACTO DEL CERTIFICADO DE DEFUNCION OFICIALMENTE INSCRITO EN EL REGISTRO DEMOGRAFICO DE PUERTO RICO BAJO LA AUTORIDAD CONFERIDA POR LA LEY 24 DEL 22 DE ABRIL DE 1931

THIS IS AN ABSTRACT OF THE RECORDS FILED IN THE DEMOGRAPHIC REGISTRY OF PUERTO RICO ISSUED UNDER THE AUTHORITY OF LAW 24, APRIL 22, 1931



DIRECTOR REGISTRO DEMOGRAFICO  
(STATE REGISTRAR)

Estado Libre Asociado de Puerto Rico  
Departamento de Salud

ADVERTENCIA: Cualquier alteración o borradura cancela esta certificación.

WARNING: Any alteration or erasure voids this certification.